STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195566	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ollie Steele Burden Manor	4250 Essen Lane Baton Rouge, LA 70809

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to store and prepare food in accordance with professional standards for food service safety by failing to ensure:1. Food was properly labeled in the walk-in refrigerator;2. Food was properly labeled in the dry storage room;3. Food was properly sealed and labeled in the walk-in freezer;4. Dietary staff maintained documentation of dishwasher temperatures;5. Dietary staff maintained documentation of 3 compartment sink temperatures and chemical sanitation levels; and 6. Dietary staff maintained documentation of Breakfast and Lunch meal temperatures. This deficient practice had the potential to affect any of the 29 residents who were served food from the facility's kitchen.Findings:Review of the facility's revised policy dated 11/2022 and titled, Food Receiving and Storage, revealed the following, in part:Policy: Foods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation:Refrigeration/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).Review of the facility's undated policy titled, Dishwasher Temperature, revealed the following, in part:Policy: It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures.Policy Explanation and Compliance Guidelines:6. Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes.Review of the facility's undated policy titled, Manual Ware Washing -3 Compartment Sink, revealed the following, in part:Policy: To prevent the spread of bacteria that may cause food borne illness, this facility washes, rinses, and sanitizes pots, pans, and other utensils using a 3 compartment sink in accordance with current standards for food safety. Policy and Compliance Guidelines:6. A temperature measuring device shall be provided by the facility and readily accessible for frequent measuring of the washing and sanitizing temperatures. 7. Sanitizing solutions shall be tested by a test kit or other device that accurately measures the concentration in milligrams/liter (MG/L). Testing will occur periodically but not limited to:a. When sink is initially filled,b. At least once per shift.Review of the facility's undated policy titled, Record of Food Temperatures, revealed the following, in part:Policy: It is the policy of this facility to record food temperatures daily to ensure food is at the proper serving temperature(s) before trays are assembled.Policy Explanation and Compliance Guidelines:1. Food temperatures will be checked on all items prepared in the dietary department. 6. Measure and record the temperatures for each food product and milk at all meals. Record temperature on temperature log. On 09/15/2025 at 9:30 a.m., an initial tour of the kitchen was conducted with S4DM who confirmed the following observations: Walk-in refrigerator:One large silver pan containing 14 individually wrapped sandwiches, not labeled or dated. Dry Storage:One 15 ounce (oz.) pack of sloppy joe mix, open, not labeled or dated;One 15 oz. taco seasoning mix, open, not labeled or dated;One package of tortillas, open, not labeled or dated;One 5 lb. bag of corn bread mix, open, not labeled or dated;One 24 oz. dry gelatin mix, open, not labeled or dated; andFour bags of dry pasta, open, not labeled or dated. Walk-in freezer:One box containing 8 croissants, open, unsealed, not labeled or dated; andOne package of mixed vegetables, open, not labeled or dated. Review of the facility's kitchen Temperature Logs revealed no recordings on the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	following dates:08/06/2025: Lunch-3 compartment sink, Dinner- Dishwashing Machine;08/12/2025: Lunch-3 compartment sink;08/29/2025: Breakfast- Dishwashing Machine, Lunch- Dishwashing Machine, and Dinner- Dishwashing Machine; 09/01/2025: Lunch Meal Temperatures, Breakfast- Dishwashing Machine, Breakfast-3 compartment sink, Lunch-3 compartment sink, Dinner- Dishwashing Machine;09/02/2025: Breakfast Meal Temperatures;09/07/2025: Lunch-3 compartment sink, Dinner- Dishwashing Machine and 3 compartment sink; and09/09/2025: Dinner- Dishwashing Machine. On 09/15/2025 at 10:10 a.m., an interview was conducted with S4DM. He stated all food items should be fully covered, and labeled with item name, opened date and discard date. He confirmed the items found were not properly stored and should have been. He stated he was responsible for reviewing the temperature logs weekly. He stated for each meal service, the dietary staff should document each food's temperature to ensure the food was at a safe temperature prior to serving to the residents. He stated dietary staff should check the dishwashing machine's wash and rinse temperatures and the 3 compartment sink's wash temperature, rinse temperature and sanitation level with each meal service to ensure they were cleaning the dishes at the right level to sanitize them. He stated the dietary staff were not consistently documenting the information and should have been. On 09/15/2025 at 4:10 p.m., an interview was conducted with S1ADM. She was made aware of the above mentioned findings. She stated she would expect opened food items to be sealed, labeled and dated. She confirmed meal temperature checks, dishwashing machine temperature checks, and 3 compartment sink temperature checks and chemical sanitation levels should have been recorded, and were not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure an infection prevention and control program was maintained to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to ensure:1. Nursing staff providing care to a resident who required Transmission Based Precautions (TBP) did not exit a resident's room wearing Personal Protective Equipment (PPE) or store a mask worn during resident care in their pocket for 1 (#62) of 2 (#2 and #62) residents reviewed on TBP; 2. Nursing staff sanitized insulin pen stoppers prior to attaching an insulin pen needle for 2 of 2 (#2 and #66) residents reviewed for insulin administration; and 3. Documentation was maintained of the annual review of the Infection Prevention Policies and Procedures.Findings: 1.Resident #62Review of Resident #62's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis, which included COVID-19. Review of Resident #62's current Care Plan revealed the following, in part:Problem: 09/12/2025-The resident has a respiratory infection Contact and Droplet Isolation due to COVID-19 diagnosis times 4 days. Review of Resident #62's Lab Results dated 09/02/2025 revealed the following, in part:SARS-CoV-2 Detection, Final Result On 09/15/2025 at 12:45 p.m., an observation was made of the Droplet Precautions and Contact Precautions signs posted on Resident #62's door. The Contact Precautions sign revealed the following, in part: Discard gloves before room exit and Discard gown before room exit. On 09/15/2025 at 12:47 p.m., an observation was made of S9CNA providing a meal tray for Resident #62. S9CNA performed hand hygiene, donned a gown, gloves, KN95 mask with a blue surgical mask on top of the KN95 mask. S9CNA entered the resident's room, walked to the foot of the resident's bed, spoke to the resident, and then turned on the room light switch. Without removing her PPE, S9CNA exited Resident #62's room, removed the disposable meal containers from the meal cart and entered Resident's #62's room. S9CNA was observed setting the meal containers on Resident #62's bedside table. Without removing her PPE, S9CNA again exited Resident #62's room and removed two plastic cups off the top of the meal cart. Wearing the same PPE, S9CNA entered Resident #62's room, moved the bedside table in front of Resident #62 and cut up the food. S9CNA then removed her gown, gloves, and blue surgical mask inside the room and placed them in the receptacle. S9CNA exited Resident #62's room, removed her KN95 mask and placed it in her pocket. On 09/15/2025 at 1:05 p.m., an interview was conducted with S9CNA. She stated Resident #62 had a COVID-19 infection. S9CNA confirmed the above observations. She stated once she entered a resident's room on isolation she should not have exited the room wearing the PPE. She confirmed she should not have placed her used mask in her pocket. On 09/17/2025 at 11:10 a.m., an interview was conducted with S3RN. She stated she was the facility's Infection Preventionist. She stated Resident #62 had a COVID-19 infection and was on contact and droplet isolation precautions. She stated staff should remove their PPE prior to exiting a resident's room who was on transmission based precautions. She stated staff should not put a used mask in their pocket as it could cause cross contamination. She stated staff should not exit the resident's room in soiled PPE to prevent bringing the organism out of the room and contaminating clean items. On 09/17/2025 at 11:12 a.m., an interview was conducted with S2DON. She stated Resident #62 had a COVID-19 infection and was on contact and droplet isolation precautions. She stated staff should not exit the resident's room with PPE on and should dispose of the soiled PPE in the biohazard box in the resident's room. She confirmed staff should not place a mask used in an isolation room in their pocket. 2.Review of the Humalog Kwik (Insulin Lispro) pen Manufacturer's Insert revealed the following, in part:Preparing your Pen:Step 1:Pull the Pen Cap straight off.Wipe the Rubber Seal with an alcohol swab. Resident #2Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis, which included Type 2 Diabetes Mellitus with Other Circulatory Complications. On 09/16/2025 at 11:25 a.m., an observation was made of S7LPN administering Resident #2's Humalog (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin. S7LPN removed Resident #2's Humalog insulin pen cap and attached the insulin pen needle without sanitizing the insulin pen stopper. S7LPN administered Resident #2's insulin. On 09/16/2025 at 11:30 a.m., an interview was conducted with S7LPN. She confirmed she did not sanitize Resident #2's insulin pen stopper prior to applying the insulin pen needle. Resident #66Review of Resident #66's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis, which included Type 2 Diabetes Mellitus with Diabetic Polyneuropathy. On 09/16/2025 at 11:36 a.m., an observation was made of S8LPN administering Resident #66's Humalog insulin. S8LPN removed Resident #66's Humalog insulin pen cap and attached the insulin pen needle without sanitizing the insulin pen stopper. S8LPN administered Resident #66's insulin. On 09/16/2025 at 12:05 p.m., an interview was conducted with S8LPN. She confirmed she did not sanitize Resident #66's insulin pen stopper prior to applying the insulin pen needle. On 09/16/2025 at 12:45 p.m., an interview was conducted with S2DON. She stated if the manufacturer says to sanitize the insulin pen stopper prior to attaching the pen needle then the nurses should clean it with an alcohol swab. 3.No documented evidence was provided to show the facility's Infection Prevention and Control Policies and Procedures were reviewed annually. On 09/16/2025 at 1:52 p.m., an interview was conducted with S3RN. She stated Interdisciplinary Team, the nurse consultant, and herself reviewed the facility's infection control policies and procedures at least annually and updated them throughout the year as needed. She stated she was unable to provide any documented evidence of the annual review.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record reviews and interviews, the facility failed to inform the resident or his/her legal representative in writing of Medicare services which may not be covered, and of the resident's/beneficiary's potential liability for payment for non-covered services. The facility failed to ensure liability notices were accurate and completed as required for 2 (#53 and #54) of 3 (#53, #54, and #61) residents reviewed for beneficiary protection notification. Findings: Review of the facility's undated policy titled, Advance Beneficiary Notices revealed the following, in part:Policy: It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage.Policy Explanation and Compliance Guidelines:4. The facility shall inform Medicare beneficiaries of his or her potential liability for payment. A liability notice shall be issued to Medicare beneficiaries upon admission or during a resident's stay, before the facility provides:a. An item or service that is usually paid for by Medicare, but may not be paid for in a particular instance because it is not medically reasonable or necessary, orb. Custodial care.5. The current CMS approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form.a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Form CMS-10055. Review of the facility's Advance Beneficiary Notice of Non-coverage Form CMS-R-131 (ABN) form revealed the following, in part:G. Options:Option 1: I want the, (fill in blank), listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.Option 2: I want the, (fill in blank), listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.Option 3: I don't want the, (fill in blank), listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay. Resident #53Review of Resident #53's Beneficiary Notification Review form revealed her Medicare Part A skilled services last covered day was 08/21/2025, and Resident #53 remained in the facility. Review of Resident #53's Advance Beneficiary Notice of Non-coverage Form CMS-R-131 (ABN) revealed it was signed and dated by Resident #53's Resident Representative on 08/19/2025. Further review revealed the following was blank on the form: what Medicare services may not be covered, estimated cost for the non-covered services, and no option choice was selected by the Resident Representative. The Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage Form CMS-10055 for Medicare Part A services was not provided for Resident #53. Resident #54Review of Resident #54's Beneficiary Notification Review form revealed her Medicare Part A skilled services last covered day was 07/04/2025, and Resident #54 remained in the facility. Review of Resident #54's Advance Beneficiary Notice of Non-coverage Form CMS-R-131 (ABN) revealed it was signed and dated by Resident #54 on 07/01/2025. Further review revealed the following was blank on the form: what Medicare services may not be covered, estimated cost for the non-covered services, and no option choice was selected by the Resident. The Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage Form CMS-10055 for Medicare Part A services was not provided for Resident #54. On 09/16/2025 at 12:15 p.m., an interview was conducted with S5BO. She stated, for traditional Medicare residents, S6LPN completed and presented the ABN forms to the residents and/or the Resident Representative. She reviewed the ABN forms provided by the facility for Residents #53 and #54 and confirmed they were incomplete. She stated the ABN form should include what services may not be covered, along with rate of the non-covered service and the resident or responsible party should choose an option 1, 2, or 3. On 09/16/2025 at 12:33 p.m., an interview was conducted with S6LPN. She stated she verbally notified residents and/or their responsible party of the upcoming discharge from skilled services, (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including what services may not be covered and their options available. She reviewed the ABN CMS-R-131 forms for Resident #53 and #54, confirmed they were incomplete and stated she only had the residents or their responsible party sign and date this form. She stated no one at the facility showed her how to complete the ABN forms. She confirmed she did not discuss the payment liability or have the resident or their representative select an option on the form. On 09/17/2025 at 9:55 a.m., an interview was conducted with S1ADM. She stated herself, S5BO, and S6LPN were responsible for obtaining resident liability notices for the facility and it was a group effort. She reviewed Resident #53 and Resident #54's ABN forms provided by the facility and confirmed the ABN forms were incomplete. She confirmed the ABN forms should be complete and accurate to include information to ensure the resident and/or their representative were informed of services that may not be covered, the estimated cost for the non-covered services and their options.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan which met the needs of 1 of 1 (#50) residents reviewed for accidents. The facility failed to ensure Resident #50 was care planned for fall risk upon admission.Findings: Review of the facility's policy titled, Comprehensive Care Plans, and dated 2025 revealed the following, in part: Policy: It is the policy of this facility to develop and implement a comprehensive, person-centered care plan for each resident, consistent with resident rights, that includes measureable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meets professional standards of quality. Policy Explanation and Compliance Guidelines: 3. The comprehensive care plan will describe, at a minimum, the following:a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of Resident #50's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Transient Ischemic Attacks, Hemiplegia and Hemiparesis affecting left, non-dominant side. Review of Resident #50's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/2025 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive deficits. Further review of Section GG-Functional Abilities, revealed, upon admission, Resident #50 was dependent on staff for transfers and walking was not performed due to current, medical condition and/or safety concerns. Review of CSC-Fall Risk Evaluation dated 08/07/2025 revealed the following, in part:1. Upon admission and quarterly, at a minimum, thereafter, observe the resident's status in the 11 clinical parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered a high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. 4. Score 10 or higher indicated the resident is at high risk of fall.Total Score: 20.0Clinical Suggestions: None were selected. Review of Resident #50's current care plan revealed his fall risk was not featured as a focus and no interventions were established to prevent falls.On 09/15/2025 at 11:32 a.m., an interview was conducted with Resident #50. He reported he had experienced several, near-falls since admission to the facility.On 09/15/2025 at 11:34 a.m., an observation was made of Resident #50's room. Two signs were observed near the bathroom entrance regarding risk of falls. One read Warning-Risk of Falling and the other read Call-Don't fall.On 09/17/2025 at 8:45 a.m., an interview was conducted with S16DOR. She stated Resident #50 was considered a high fall risk due to residual, physical impairments and impulsivity. She stated Resident #50 had previously attempted to toilet independently, which could have resulted in a fall.On 09/17/2025 at 9:07 a.m., an interview was conducted with S17MDS. She stated she was responsible for completing Resident #50's care plan. She confirmed Resident #50 was at risk for falls. She reviewed Resident #50's current care plan and confirmed he was not care planned for fall risk and should have been.On 09/17/2025 at 10:45 a.m., an interview was conducted with S2DON. She stated she expected all residents identified at risk for falls to be care planned accordingly. She reviewed Resident #50's fall risk assessment and confirmed he was at high risk for falls. She reviewed his care plan and confirmed he was not care planned for fall risk and should have been.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure each residents' care plan was reviewed and revised for 1 of 1 (#21) residents reviewed for Activities of Daily Living (ADL). The facility failed to update Resident #21's care plan after 11/05/2024, when she required a mechanical lift for transfers. Findings: Review of the facility's policy titled, Comprehensive Care Plans, and dated 2025 revealed the following, in part: Policy: It is the policy of this facility to develop and implement a comprehensive, person-centered care plan for each resident, consistent with resident rights, that includes measureable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meets professional standards of quality. Policy Explanation and Compliance Guidelines: 5. The comprehensive, care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. Review of Resident #21's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Cerebral Infarction, Hemiplegia and Hemiparesis affecting left, non-dominant side. Review of Resident #21's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/21/2025 revealed Resident #21 was dependent on staff for transfers. Review of Resident #21's current Care Plan revealed the following, in part: Focus: The resident has an ADL self-care performance deficit related to activity intolerance, confusion, fatigue, and impaired balance.Interventions:Transfer: The resident is dependent on staff for transferring. Date initiated: 10/11/2024 Review of Resident #21's Therapy Communication form dated 11/05/2024, displayed above her bed revealed the following, in part:Special Instructions: Mechanical lift transfers On 09/16/2025 at 9:24 a.m., an observation was made of Resident #21 being transferred from bed to wheelchair via mechanical lift by S12CNA and S13RN. On 09/16/2025 at 10:11 a.m., an interview was conducted with S14ROT. She stated the therapy department was responsible for determining whether or not a resident required a mechanical lift for transfers. She stated any changes to a resident's assist level or need for assistive devices were communicated to nursing staff verbally and through the Therapy Communication form displayed above each resident's bed. She confirmed Resident #21 required a mechanical lift for transfers. On 09/16/2025 at 10:37 a.m., an interview was conducted with S15MDS. She stated she was responsible for reviewing and revising Resident #21's care plan. She confirmed Resident #21 required a mechanical lift for transfers. She reviewed Resident #21's current care plan and confirmed it had not been revised to include her need for a mechanical lift during transfers and should have been. On 09/17/2025 at 10:45 a.m., an interview was conducted with S2DON. She stated she expected a resident's need for a mechanical lift during transfers to be reflected on their care plan. She reviewed Resident #21's current care plan and confirmed it had not been revised to include her need for mechanical lift during transfers and should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the services provided as outlined in the comprehensive care plan met professional standards of quality by failing to ensure nursing staff primed insulin pen needles prior to administering insulin for 2 of 2 (#2 and #66) residents reviewed for insulin administration.Findings: Review of the Humalog (Insulin Lispro) Kwik pen Manufacturer's Insert revealed the following, in part:Step 4: Push the capped Needle straight onto the Pen and twist the Needle on until it is tight.Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.Step 6: To prime your Pen, turn the Dose Knob to select 2 units.Step 7: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top.Step 8: Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and 0 is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the Needle and repeat priming steps 6 to 8. Review of the facility's insulin pen needles manufacturer's guidelines revealed the following, in part:2. Place the pen needle straight on the pen injector device and tighten.5. Face the needle tip up, flick the pen to make any bubbles float to the top and press the injection button until the liquid flows out through the needle tip. Resident #2Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus with Other Circulatory Complications. Review of Resident #2's current Physician Orders revealed the following, in part:Order date: 06/27/2025; Humalog Kwik Pen 100 unit/ml, inject per sliding scale, subcutaneously before meals and at bedtime. Resident #2's Humalog Insulin sliding scale order was 8 units of insulin for a blood glucose level of 351 to 400 mg/dL. On 09/16/2025 at 11:25 a.m., an observation was made of S7LPN administering Resident #2's Humalog insulin. Resident #2's blood glucose level was 352 mg/dL. S7LPN applied the insulin pen needle, dialed up 8 units of insulin, and administered the insulin. S7LPN did not prime the insulin pen needle prior to administering the insulin. On 09/16/2025 at 11:30 a.m., an interview was conducted with S7LPN. S7LPN confirmed she did not prime the insulin pen needle prior to administering insulin to Resident #2. She stated priming the insulin pen needle was not needed prior to insulin administration. Resident #66Review of Resident #66's Clinical Record revealed she was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus with Diabetic Polyneuropathy. Review of Resident #66's current Physician Orders revealed the following, in part:Order date: 09/04/2025; Humalog (Insulin Lispro) Pen 100 unit/ml, inject per sliding scale, subcutaneously before meals and at bedtime. Resident #66's Humalog Insulin sliding scale order was 6 units of insulin for a blood glucose level of 301 to 350 mg/dL. On 09/16/2025 at 11:36 a.m., an observation was made of S8LPN administering Resident #66's Humalog insulin. Resident #66's blood glucose level was 330 mg/dL. S8LPN applied the insulin pen needle, dialed up 6 units of insulin, and administered the insulin. S8LPN did not prime the insulin pen needle prior to administering the insulin. On 09/16/2025 at 12:05 p.m., an interview was conducted with S8LPN. S8LPN confirmed she did not prime the insulin pen needle prior to administering insulin to Resident #66. She stated priming the insulin pen needle was not needed prior to insulin administration. On 09/16/2025 at 12:45 p.m., an interview was conducted with S2DON. She was made aware of the above mentioned observations. She stated insulin pen needles should be primed per the insulin pen and pen needles manufacturer's guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195566	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ollie Steele Burden Manor	4250 Essen Lane Baton Rouge, LA 70809

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations and interviews, the facility failed to provide necessary care and services for the provision of respiratory care in accordance with professional standards of practice. The facility failed to properly label respiratory care equipment for 1 of 1 (#2) resident investigated for respiratory care.Review of the facility's undated policy titled, Departmental (Respiratory Infection)-Prevention of Infection revealed, in part:Steps in the Procedure:Infection Control Considerations Related to Oxygen Administration:7. Change the oxygen cannula and tubing every seven (7) days, or as needed. Review of Resident #2's Clinical record revealed an admission date of 06/26/2025 and diagnoses, which included Pulmonary Hypertension and Congestive Heart Failure. Review of Resident #2's current Physician Orders revealed an order for Oxygen at 2 Liters per minute per nasal cannula as needed. Review of Resident #2's current care plan revealed the following, in part:Problem: The resident has shortness of breath.Goal: The resident will maintain normal breathing pattern as evidenced by eupnoea, normal skin color, and regular respiratory rate/pattern. Intervention: Check pulse oximetry, if less than 95%, administer Oxygen at 2 Liters per minute via nasal cannula. On 09/15/2025 at 11:20 a.m., an observation was made of Resident #2 sitting in her wheelchair at her bedside. Resident #2 had Oxygen in place via nasal cannula flowing at 2 Liters per minute. The oxygen tubing and humidification bottle were not labeled or dated. On 09/16/2025 at 9:10 a.m., an observation was made of Resident #2 sitting in her wheelchair at her bedside. Resident #2 had Oxygen in place via nasal cannula flowing at 2 Liters per minute. The oxygen tubing and humidification bottle were not labeled or dated. On 09/16/2025 at 9:16 a.m., an interview was conducted with S7LPN. She stated oxygen tubing and humidification bottles should have been changed on Saturday night shift. S7LPN observed Resident #2's oxygen tubing and humidification bottle at that time. S7LPN confirmed Resident #2's oxygen tubing and humidification bottle were not labeled or dated, and should have been. On 09/17/2025 at 10:47 a.m., an interview was conducted with S2DON. She stated she expected oxygen tubing and humidification bottles to be changed on Saturday night shift. She stated both the oxygen tubing and humidification bottle should have been labeled and dated.

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	195566	A. Building B. Wing	09/17/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure medications were stored and labeled properly in accordance with current accepted professional principles. The facility failed to ensure: 1. Insulin pens were labeled with an open date in 1 (Cart C) of 3 (Cart A, Cart B and Cart C) medication carts reviewed, and2. An expired medication was not available for use in 1 (Med Room A) of 2 (Med Room A and Med Room B) medication rooms reviewed.Findings: Review of the facility's undated policy titled, Medication Storage revealed the following, in part: Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation. 1. Review of the Humalog (Insulin Lispro) Kwik pen Manufacturer's Insert revealed the following, in part:Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen. Resident #2Review of Resident #2's Clinical Record revealed she was admitted to the facility on [DATE]. Further review revealed a Physician's Order for Humalog Kwik Pen 100 unit/ml, inject per sliding scale, subcutaneously before meals and at bedtime. Resident #30Review of Resident #30's Clinical Record revealed she was admitted to the facility on [DATE]. Further review revealed a Physician's Order for Humalog Kwik Pen 100 unit/ml, inject per sliding scale, subcutaneously before meals and at bedtime. On [DATE] at 10:38 a.m., an observation was made of Cart C with S7LPN. The following was observed:One Humalog Kwik pen 100 units/mL for Resident #2, was opened and not labelled with the open date; andOne Humalog Kwik pen 100 units/mL for Resident #30, was opened and not labelled with the open date. On [DATE] at 10:44 a.m., an interview was conducted with S7LPN. She confirmed the above observations. She stated she did not label insulin pens with the opened date. She stated she went by the expiration date on the insulin pen to know when to discard it. She stated she was unaware Humalog insulin Kwik pens expired 28 days after opening. On [DATE] at 12:45 p.m., an interview was conducted with S2DON. She stated the nurses on the hall were responsible for checking the medication carts for unlabeled medications. She was notified of the above observations. She stated insulin pens should be labeled with the date opened and used per manufacturer guidelines. 2. On [DATE] at 11:55 a.m., an observation was made of Med Room A with S2DON. The following was observed:One opened bottle of Fish Oil 1000 mg with an expiration date of 06/2025. On [DATE] at 12:00 p.m., an interview was conducted with S2DON. She confirmed the above observation. She confirmed the Fish Oil was expired, available for use and should have been discarded.

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	195566	A. Building B. Wing	09/17/2025

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Ollie Steele Burden Manor	4250 Essen Lane Baton Rouge, LA 70809

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on record review, observations and interviews, the facility failed to ensure garbage and waste were properly contained in the outdoor trash dumpsters.Findings: Review of the facility's undated policy titled, Disposal of Garbage and Refuse, revealed the following, in part:Policy: The facility shall properly dispose of kitchen garbage and refuse.Policy Explanation and Compliance Guidelines:7. Containers and dumpsters shall be kept covered when not being loaded. On 09/15/2025 at 10:15 a.m., an observation was made of the facility's two outdoor trash dumpsters with S4DM. One of the dumpsters was observed with one of the two lids open and half full of trash. The second dumpster was observed with both lids open and half full of trash. On 09/15/2025 at 10:20 a.m., an interview was conducted with S4DM. He confirmed the above observation. He confirmed the dumpster lids should be kept closed when not in use. On 09/15/2025 at 4:10 p.m., an interview was conducted with S1ADM. She was made aware of the above observation of the dumpster lids being open. She confirmed the dumpster lids should be kept closed when not in use.

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	195566	A. Building B. Wing	09/17/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to meet the following Hospice requirements by failing to: 1. Designate a member of the facility's interdisciplinary team (IDT) to be responsible for working with Hospice representatives to coordinate care of the resident provided by facility and Hospice staff for 1 of 1 (#4) residents reviewed for Hospice care; and2. Maintain a system to ensure a Hospice resident's Hospice Binder contained most current Hospice plan of care for 1 of 1 (#4) residents reviewed for Hospice care. A review of Resident #4's Clinical Record revealed he was admitted to the facility on [DATE]. Further review revealed Resident #4 was admitted to a local hospice agency on 06/07/2025 with a current Certification Period of 09/04/2025 thru 12/02/2025. A review of Resident #4's Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/10/2025 revealed the following, in part, Section O- K1. Hospice Care - Yes. On 09/17/2025 at 11:30 a.m., a review of Resident #4's Hospice Plan of Care revealed the most recent Plan of Care on file in the Hospice Binder was for the Certification Period of 06/06/2025 through 09/03/2025. On 09/17/2025 at 11:45 a.m., an interview was conducted with S2DON. She stated the floor nurse was responsible for ensuring the hospice binder maintained up to date certification periods and plans of care on file. S2DON reviewed and confirmed the plan of care on file was not up to date with current certification period on file. On 09/17/2025 at 12:05 p.m., an interview was conducted with S10LPN. She stated she was unaware it was her responsibility to ensure the Hospice binder maintained the most current plan of care. S10LPN stated S11CSR updated the hospice binder on an as needed basis. On 09/17/2025 at 12:10 p.m., an interview was conducted with S11CSR. She stated she was unaware any facility staff member was assigned to ensure the Hospice binder maintained the most current plan of care. She stated she filed the certification period and plan of care in the clinical record but never double checked behind the hospice nurse to ensure documents provided were current and up to date.